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Citation for published version:

European Research Network on Intracerebral Haemorrhage, Steiner, T, Petersson, J, Al-Shahi Salman, R, Christensen, H, Cordonnier, C, Csiba, L, Harnof, S, Krieger, D, Mendelow, D, Molina, C, Montaner, J, Overgaard, K, Roine, RO, Schmutzhard, E, Tatlisumak, T, Toni, D & Stapf, C 2011, 'European research priorities for intracerebral haemorrhage', *Cerebrovascular diseases (Basel, Switzerland)*, vol. 32, no. 5, pp. 409-19. <https://doi.org/10.1159/000330653>

Digital Object Identifier (DOI):

[10.1159/000330653](https://doi.org/10.1159/000330653)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Publisher's PDF, also known as Version of record

Published In:

Cerebrovascular diseases (Basel, Switzerland)

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European Research Priorities for Intracerebral Haemorrhage

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Key Words

Intracerebral haemorrhage · Oedema · Stroke · Mortality ·
Disability · Outcome · Pathophysiology · Epidemiology ·
Imaging

Abstract

Over 2 million people are affected by intracerebral haemorrhage (ICH) worldwide every year, one third of them dying within 1 month, and many survivors being left with permanent disability. Unlike most other stroke types, the incidence, morbidity and mortality of ICH have not declined over time. No standardised diagnostic workup for the detection of the various underlying causes of ICH currently exists, and the evidence for medical or surgical therapeutic interventions re-

mains limited. A dedicated European research programme for ICH is needed to identify ways to reduce the burden of ICH-related death and disability. The European Research Network on Intracerebral Haemorrhage EURONICH is a multidisciplinary academic research collaboration that has been established to define current research priorities and to conduct large clinical studies on all aspects of ICH.

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Epidemiology of Intracerebral Haemorrhage

Intracerebral haemorrhage (ICH) encompasses a diverse range of conditions, with different underlying causes, but similarly poor outcomes [1]. In brief, causes of

ICH can be differentiated into arterial small and large vessel disease, venous disease, vascular malformation, haemostatic disorders, ICH in the context of other diseases and conditions, and spontaneous. 'Spontaneous' means that no cause has been found with the currently available diagnostic tests, though it is assumed that there is a cause (cryptogenic). Spontaneous also includes that no cause has been found so far, and there is no suspicion about a concept for a cause (idiopathic). A proposal for a detailed ICH classification by causes is currently prepared in the frame of the new ICH guidelines from the European Stroke Organisation. Spontaneous ICH, which is apparently unrelated to trauma, has incurred unchanged global burden over the past decades [2, 3]. In contrast to the declining incidence of ischaemic stroke in high-income countries [4], the incidence of ICH has been constant [3]. Worldwide, the World Health Organisation estimates that 15.3 million strokes occur every year [5], of which 2–3 million are haemorrhagic. The cost of stroke in the European Union has been estimated at 27 billion EUR, of which 8.5 billion EUR are indirect costs [6]. The additional cost of ICH is estimated to be 30,000–45,000 EUR/survivor every year [7].

During the last decade, spontaneous ICH accounted for approximately 10% of strokes in high-income countries and about 20% of strokes in low-/middle-income countries, with 1-month case fatalities of 25–35 and 30–48%, respectively [4]. Cerebrovascular disease mortality also varies widely in Europe [8]. Unfortunately, the 1-month case fatality after ICH does not appear to have changed over the last few decades [3]. This is in contrast to the recent decline in the case fatality after subarachnoid haemorrhage [9, 10], which may be explained by multiple factors [11], including advances in endovascular treatment of intracranial aneurysms and intensive care after intervention [9, 12].

The incidence of spontaneous ICH is higher in Asians [3], and the major risk factors for ICH include male gender, increasing age, arterial hypertension, excessive alcohol consumption, smoking, diabetes mellitus, poor diet and obesity (waist-to-hip ratio) [13, 14]. However, over the past decades, the incidence of ICH associated with pre-stroke hypertension appears to have declined, whereas ICH associated with use of antithrombotic drugs and presumed cerebral amyloid angiopathy in those aged ≥ 75 years seems to have increased [2].

Impact for Research

As life expectancy rises, so will the burden of ICH. We need a better understanding of the roles of various risk

factors for ICH in the elderly, to what extent they are causal and modifiable, and whether demographic transitions in low-income countries and low social status result in a larger proportion of deaths being due to ICH.

We need more information on ICH epidemiology in low- and middle-income countries to compare racial, ethnic and population differences, as well as more estimates of ICH case fatality rates during different epochs in order to understand why they appear to have declined in some regions but not in others [3].

A joint prospective multinational study on the incidence, prevalence and socio-economic impact of spontaneous ICH – ideally – in all European Union countries is needed to propose more specific actions to be taken by health authorities at European and national levels.

Pathophysiology of ICH and Impact of Brain Banking

Most data on the pathophysiology of human ICH come from early macroscopic autopsy studies and describe neural damage from the hydrostatic pressure of ICH. Most instances of ICH occur when small (50- to 700- μm) penetrating arteries rupture with subsequent leaking of arterial blood into the brain parenchyma. The mass effect of the haematoma destroys neighbouring brain structures and compresses remote brain regions by midline shift and herniation. Rebleeding or haematoma growth and intraventricular expansion complicate the ICH in up to 70% of all patients within 24 h [15]. The fixed shape of the cranium limits its capacity to accommodate the volumetric ICH expansion, and haematoma volumes over 150 ml almost inevitably lead to death.

The intact or partially intact brain tissue around the haematoma may resemble ischaemic brain, and neurons may die by similar mechanisms or may be subject to toxic effects of blood products. However, studies have been contradictory about the presence, extent and severity of any penumbra around ICH. Blood-brain barrier disruption and leakage of fluids and proteins contribute to brain oedema, which commonly increases over several days and may further damage the brain [16]. At a later stage, erythrocyte lysis and release of haemoglobin metabolites, iron and thrombin have been shown to trigger neurotoxic and apoptotic mechanisms in animals [17, 18]. Another potential pathogenetic mechanism is activation of leucocytes at the injury site within the first few days, attributable to the widespread inflammation seen in animal models of ICH. All injuries to brain tissue also change genomic expression in the brain [19], which is a largely

unexplored phenomenon in ICH patients. Experimental studies, mostly in rodents, have expanded our knowledge of pathophysiology, but are lacking confirmation in human studies so far. Furthermore, the two most popular rodent ICH models are not entirely comparable to human ICH, and despite their usefulness in some aspects they cannot replace human tissue examinations [20].

Impact for Research

Development of novel treatments requires a precise understanding of the underlying pathophysiology and molecular mechanisms of ICH-related brain injury. Therefore, there is an urgent need for establishing large multicentre human ICH brain banks based on samples from within the haematoma, the vicinity of the haematoma, as well as from remote brain regions from patients who die at different time points following ICH, in order to systematically study macroscopic, microscopic and ultrastructural changes.

Also, it is necessary to examine the roles of candidate molecules in causing ICH-related brain damage, to map cellular and molecular migration patterns, to study arterial wall microstructure, and to decipher post-ICH brain genetics and proteomics in sufficiently large samples.

Additionally, blood samples should be collected from ICH patients at various phases of the disease and stored for future research on biomarkers including genome-wide association studies and candidate gene identification with micro-arrays.

ICH Imaging and Diagnostic Workup

Studies on sensitivity and specificity of prehospital clinical diagnosis of ICH are contradictory [21–28]. Therefore, brain imaging is the cornerstone for ICH diagnosis because haemorrhagic and ischaemic stroke cannot be differentiated on clinical grounds alone. Brain computed tomography (CT) detects symptomatic ICH within minutes of symptom onset but may lack sensitivity if the bleeding is hyperacute (uncoagulated blood) or CT brain imaging is delayed for more than 1 week after ICH onset (hematoma isodense to brain tissue) [29]. Magnetic resonance imaging (MRI) with T₂*-weighted gradient-recalled echo sequences identifies ICH soon after onset and reliably detects chronic posthaemorrhagic iron deposits [30]. Initial imaging may also be used as part of prognostic scores predicting clinical outcome after acute ICH [31]. Hyperacute CT angiography followed by a postcontrast scan may in up to 40% identify a ‘spot

sign’ – 1 or more hyperintense spots in the haematoma – representing a contrast leak. Its presence is a recently established predictor of haematoma expansion and poor outcome [32–34]. E-learning programmes may permit easy implementation in clinical practice [35].

After the ascertainment of the haemorrhagic nature of the stroke, a swift diagnosis of the underlying cause can expedite management to improve outcome or prevent recurrent ICH. For both MRI and CT, baseline and serial studies can be used to identify patients who may benefit from acute interventions (e.g. anticoagulation for intracranial venous thrombosis or placement of an external ventricular drain for hydrocephalus). The reliable detection of an underlying arterial aneurysm, arteriovenous malformation or dural arteriovenous fistula may require additional intra-arterial digital subtraction angiography because timely treatment can prevent recurrent ICH [1].

In line with the low level of evidence of the existing international recommendations [36–38], clinical practice varies widely across Europe: In a survey of current practice, the types and timing of investigations varied considerably between specialties and countries. Generally, younger age, a lobar bleeding location and the absence of pre-existing arterial hypertension prompt further diagnostic studies beyond the initial CT imaging [39]. None of these factors, however, reliably predicts any underlying vascular pathology. MRI and angiographic imaging seem worthwhile depending on the patient’s clinical condition [40], but the availability and choice of these modalities will depend on local resources, regional standards and national healthcare systems. Until further studies of the diagnostic accuracy of non-invasive investigations such as CT or magnetic resonance angiography have been performed, these techniques cannot replace intra-arterial digital subtraction angiography for the investigation of ICH [39].

Impact for Research

Given the large variety of underlying vascular pathologies, the concept of ‘primary’ ICH should be replaced by a more systematic stratification into specific diagnostic subtypes. Testable ICH standard diagnostic criteria need to be defined by underlying aetiology, including working criteria for diagnostic certainty according to imaging and other diagnostic tools.

The increasing sensitivity of diagnostic tests, changes in the epidemiology of ICH and discovery of newly identified risk factors ask for a new classification of ICH according to aetiological subgroups. Planned as part of the updated European Stroke Organisation guidelines on ICH diagnosis and management, a new ICH classifica-

tion will help to standardise inclusion criteria for future observational research and controlled clinical trials.

Future research should also focus on the appropriate type and timing of diagnostic investigations after spontaneous ICH onset. This includes development of a decision tree defining standard diagnostic and management algorithms, and the most cost-effective strategies for investigating patients at older ages and in resource-poor settings.

More refined imaging tools and diagnostic signs (e.g. the spot sign on postcontrast multidetector row CT) may help to better define subgroups at risk for haematoma expansion or rebleeding [32, 41]. Only few reports exist on the spot sign on contrast-enhanced MRI [42, 43] and warrant further study. This may improve patient selection for future clinical trials in acute ICH as patients with a high risk of haematoma expansion may also show the highest treatment effect [44, 45].

Alternative imaging tools, such as transcranial ultrasound, should be explored for early ICH diagnosis and non-invasive follow-up imaging [46]. Clinical grading scales predicting outcome after ICH could be improved by identifying the underlying cause and incorporating more specific imaging data [47].

Prevention

Currently established predictors of ICH include modifiable risk factors (arterial hypertension, diabetes mellitus, excessive alcohol consumption, smoking, poor diet, overweight, quality of anticoagulant therapy) and non-modifiable risk factors such as male gender, increasing age, ethnic origin and certain genetic predispositions [13, 48]. Presence of 1 or more of these factors may lead to subsequent structural changes of the small brain vessels, including arteriolosclerosis, lipohyalinosis and eventual formation of micro-aneurysms. The various effects of many risk factors may result in so-called cerebral small vessel disease, which underlies many ICH cases. The population prevalence of cerebral small vessel disease – even without ICH – increases with age and may lead to progressive cognitive decline and mainly determines the burden of vascular dementia in the general population.

Medical Prevention of ICH

As for ischaemic stroke prevention, guidelines recommend that survivors of ICH should stop smoking, limit their alcohol consumption and actively treat any con-

comitant risk factors mentioned above, in particular elevated blood pressure [36–38]. After the acute phase of ICH, the large randomised PROGRESS trial found that blood pressure reduction (using the angiotensin-converting enzyme inhibitor perindopril and the diuretic indapamide) was beneficial in the prevention of future vascular events [49]. The effect was particularly strong for secondary prevention of ICH: an average systolic blood pressure reduction of 12 mm Hg decreased the risk of recurrent ICH by up to 76% [50].

ICH prevention (primary and secondary) becomes particularly important in patients with a need for oral anticoagulation [51]. The introduction of new oral anticoagulants may decrease the risk of (re)bleeding compared to warfarin by as much as 1/3 to 2/3 [52–54]. However, the problem of oral anticoagulant therapy-related ICH will remain and possibly even increase in absolute numbers. There are two reasons for this: (1) the new drugs may be prescribed more liberally because of a better safety profile, and (2) the number of patients with atrial fibrillation is expected to increase substantially over the next decade [55]. Just as for warfarin-related ICH, questions like best acute treatment and restart of secondary prevention will need to be answered.

Surgical Prevention of ICH

The quality of non-invasive brain imaging tools, such as CT, MRI, as well as vascular imaging by means of CT angiography and magnetic resonance angiography, has improved constantly over the past. The increased accessibility leads to a growing number of incidentally diagnosed haemorrhage-prone vascular malformations at a stage before actual ICH or even clinical symptoms have occurred. Unruptured aneurysms, unruptured brain arteriovenous malformations and incidental cavernous malformations often represent a management dilemma because treatment decisions have to consider the risk of invasive versus non-invasive strategies. Depending on lesion type, size and location, possible interventional techniques include neurosurgery, endovascular embolisation or stereotactic radiosurgery. So far, however, no controlled clinical study has proven the clinical benefit of any of such interventions for primary haemorrhage prevention in affected patients [56].

Impact for Research

Longitudinal population-based cohort studies will have to test the preventive effect of active risk factor mod-

ification on the incidence and recurrence rate of ICH. The impact may be different according to subtypes of underlying small vessel disease (e.g. amyloid angiopathy, hypertension-induced arteriolosclerosis or genetic small vessel disease). Improved risk factor management may also have a favourable effect on the burden of vascular dementia in the general population. Also, there is a need for studying the double risk of stroke with small vessel disease (ischaemic and haemorrhagic stroke) in future ICH research, including adequate outcome measures in future ICH research.

For an increasing number of patients diagnosed with haemorrhage-prone but as yet unruptured vascular lesions (such as aneurysms, arteriovenous or cavernous malformations), controlled clinical ICH prevention trials are needed to compare the risk/benefit ratio of preventive lesion eradication versus non-interventional management. One international randomised clinical trial evaluating the management of unruptured brain arteriovenous malformations is currently ongoing (www.arubastudy.org) including many study sites across Europe.

Acute Medical ICH Treatment

Stroke Unit and Neurocritical Care Unit Management

The latest Cochrane Review update by the Stroke Unit Trialists' Collaboration confirmed the benefit of stroke unit care for unselected stroke patients [57]. Admission to a neurological/neurosurgical intensive care unit has been shown to be associated with a reduced mortality rate after ICH in an observational study design [58]. While there are no indications that patients with ICH have less benefit than patients with ischaemic stroke, studies were not powered to detect such differences. The European Stroke Organisation guidelines recommend standard stroke care defined as dedicated care with trained personnel, monitoring of physiological parameters and early mobilisation. There is largely only class IV evidence for any single general care item such as antibiotic treatment of respiratory infections, early mobilisation or use of a nasogastric tube. Whether patients with ICH respond differently to any of these measures is unclear, and early decision-making regarding 'do not resuscitate' orders may systematically bias available data sets [59].

Volume of ICH and presence of intraventricular haemorrhage were repeatedly found to be the two major predictors of death or severe disability in the acute phase after spontaneous ICH [60–62]. Volumes of ICH or intraventricular haemorrhage or both increase within 24 h in

at least 70% of patients [15]. Therefore, treatments aimed at reduction of volume, restriction of growth and removal of ventricular haemorrhage may improve outcome. Furthermore, increasing perihematoma oedema may add to the mass effect. However, the association between perihematoma oedema and acute/subacute morbidity and mortality appears contradictory [63, 64].

Methods to predict the likelihood of ICH growth have been proposed and need verification (e.g. density and shape of the ICH on CT [65], or spot sign on CT angiography [32, 34, 45]). Haematoma expansion may also lead to increased intracranial pressure. Patients with a Glasgow Coma Scale score ≤ 8 requiring intubation and artificial ventilation may benefit from an intraventricular or parenchymal intracranial pressure monitoring. Increased intracranial pressure is treated according to accepted general guidelines, including osmotherapy (mannitol or hypertonic saline as boluses), and intermittent cautious short-term hyperventilation (aiming at pCO_2 32–35 mm Hg), whereas decompressive craniectomy and moderate hypothermia might be efficacious [36, 37]. However, none of these procedures has been subject to controlled clinical trials.

Haemostatic Therapy

Non-surgical concepts to restrict growth include the use of haemostatic agents and blood pressure lowering. ϵ -Amino caproic acid (EACA), tranexamic acid (TXA) and activated recombinant factor VII (rFVIIa) were used in trials for spontaneous ICH [61, 66–68].

The 4 randomized controlled trials of haemostatic drugs for acute ICH included 423 placebo and 975 patients who received haemostatic drug, 973 on rFVIIa and 2 EACA, and thus this comparison was mainly a comparison between placebo and rFVIIa [69]. Haemostatic drug therapy did not reduce the case fatality and risk of death and dependency on modified Rankin Scale within 90 days, despite a significant reduction in haematoma growth. There was a trend towards more participants on rFVIIa experiencing thrombo-embolic serious adverse events. A post hoc analysis suggested several reasons why the largest haemostatic drug trial (FAST [61]) showed a neutral result, including a treatment time window beyond 2.5 h, median patient age >70 years, average intraventricular haemorrhage volume >5 ml, and ICH volume of more than 60 ml [44]. This implies that a shorter time to detection (e.g. by CT) may improve the power of subsequent trials.

EACA was evaluated in a small retrospective study, which included 5 patients within 12 h after an acute ICH. These patients were treated with EACA intravenously 5 g during the 1st hour and with 1 g/h during the following 23 h [66]. Haematoma enlargement occurred in 3 of 5 patients, while it occurred in 2 of 9 patients who were not treated with EACA.

TXA works when the coagulation mechanism has been set off and exhibits its haemostatic effect by inhibiting plasminogen [70], thereby inhibiting the cascade of enzymes which dissolve a thrombus. Its use for a variety of other indications suggests that it may be effective in reducing ICH growth. A protocol of rapid infusion of TXA (2 g over 10 min) and blood pressure restriction (systolic blood pressure below 150 mm Hg) was used in 223 consecutive and retrospectively analysed patients within 24 h after spontaneous ICH [67]. Haematoma enlargement (defined as $\geq 20\%$ volume increase) was observed in 8 (4.3%) of 188 patients. The CRASH-2 trial included trauma patients and compared the risk of death due to bleeding in 10,096 patients who were treated with TXA and 10,115 who received placebo. Death due to bleeding was significantly reduced from 574 (5.7%) in the placebo group to 489 (4.9%) in the TXA group for all causes of trauma [71]. No significant difference was found in the subgroup of patients with traumatic brain injury, though the trial was not powered for this analysis. A Cochrane review of the randomised trials with TXA in patients undergoing elective surgery identified 53 studies including 3,836 participants [72], and TXA reduced the need for blood transfusion by one third. TXA has been shown to decrease early rebleeding after aneurysmal subarachnoid haemorrhage from 10.8% among controls to 2.4%, while reducing mortality from 16.3 to 12.9%; however, the doses and treatment durations differ from those used for ICH so far [73]. Whether the occurrence of thrombo-embolic complications is different, e.g. compared with rFVIIa treatment, is not known.

Blood Pressure Control

Mechanistically it seems plausible that elevated blood pressure is a driving force for haematoma enlargement. On the other hand, lowering blood pressure too much may lead to ischaemia. However, several recent publications suggest the latter being less important [74, 75]. After positron emission tomography studies had found no evidence of hypoperfusion or increased oxygen extraction in the brain tissue surrounding the ICH, it was assumed that

antihypertensive treatment would not harm the perihæmatomal tissue [76]. Intensive lowering of blood pressure was applied in the 'intensive blood pressure reduction in acute cerebral haemorrhage trial' (INTERACT) [77]. Overall, 400 patients were randomised to either intensive (systolic blood pressure ≤ 140 mm Hg within 1 h) or guideline-based blood pressure treatment (systolic blood pressure ≤ 180 mm Hg). Intensive blood pressure restriction for 7 days turned out to be feasible, safe and to reduce haematoma growth on 24-hour follow-up imaging. The Antihypertensive Treatment of Acute Cerebral Haemorrhage (ATACH) trial looked at three different blood pressure target groups in an escalating design – blood pressure was kept within 3 different ranges for 18–24 h: group 1 ($n = 18$) 170–200 mm Hg, group 2 ($n = 20$) 140–170 mm Hg and group 3 ($n = 22$) 110–140 mm Hg [78]. The observed proportions of neurological deterioration and serious adverse events were below the prespecified safety thresholds, and the 3-month mortality rate was lower than expected in all systolic blood pressure tiers.

Impact for Research

The application of haemostatic drugs in spontaneous ICH seems to reduce haematoma growth, despite the fact that different definitions of growth or haematoma enlargement were used [79]. Still there is no study that has shown that reduction of haematoma enlargement has a beneficial clinical effect. By far, most information has come from trials on rFVIIa, but other drugs, e.g. TXA, might turn out to be effective. The INTERACT 2 phase III trial is ongoing to establish the efficacy and safety of aggressive blood pressure lowering compared to guideline-based blood pressure targets on death and dependency at 3 months; the trial includes many sites in Europe [80]. The interaction between haemostatic and antihypertensive approaches to treatment will need to be established as part of subsequent haemostatic drug trials.

ICH and ischemic stroke trials have some aspects in common, for example outcome predictors such as time window, lesion volume and clinical status on admission, or outcome measures like modified Rankin Score, National Institutes of Health Stroke Scale, Glasgow Outcome Score or Barthel index. Yet, important differences should be considered in ICH research, particularly outcome predictors like intraventricular volume, haematoma expansion predictors like spot sign and outcome measures like socio-economic impact and the association between risk factors and pathology (e.g. hypertension and location). Another factor that needs to be studied further is the impact of do-not-resuscitate orders on outcome in ICH.

Acute Surgical ICH treatment

About 10% of spontaneous ICH are located in the brainstem or cerebellum [81]. Current guidelines recommend evacuation of cerebellar ICH when its diameter exceeds 2–3 cm, if symptomatic hydrocephalus is present or if brainstem compression arises [37, 38]. The application of an external ventricular drain is recommended in case of hydrocephalus and signs of clinical deterioration. None of these recommendations are based on prospective clinical trials with clearly defined selection criteria. The same holds true for the management of external ventricular drains during the course of the disease [82, 83].

While there is little doubt that the removal of an expanding posterior fossa haematoma improves acute ICH outcome, controversy exists about surgical interventions for spontaneous supratentorial ICH. Data collected from non-randomised studies have usually shown that the outcome has been worse in the surgically treated group. This is because the most severely affected patients have been subjected to surgery while the less severe cases have been treated conservatively [84].

The STICH trial was the largest prospective randomised controlled trial of early surgery compared with initial conservative treatment [85]. In this study, 1,033 patients were randomised within 72 h to initial conservative treatment or early surgery. The result was neutral for death and disability at 3 months, but a subgroup analysis suggested that superficial lobar haematomas treated with craniotomy were more likely to benefit from early surgical intervention.

A meta-analysis of the 13 prospective randomised controlled trials of surgery versus conservative treatment has demonstrated a significant reduction in mortality and a strong indication of reduced morbidity as well [86, 87]. A 14th trial has recently been published also suggesting that (minimally invasive) surgical intervention is of value [88]. One problem of small trials that looked at surgery within 4 h though was an increased rate of rebleeding [89].

Impact for Research

Both ICH and intraventricular haematoma volumes play a key role in the management of ICH. As in other stroke types, the timing between ICH onset and treatment initiation in any surgical ICH trial may be crucial, since most of the volume expansion occurs within the first 24 h.

The role of surgery within this time frame is as yet unclear, but the issue is subject to several currently ongoing clinical trials: one prospective randomised controlled tri-

al has been initiated (STICH II) to test the effect of surgery in patients with superficial lobar haematomas without ventricular haemorrhage or hydrocephalus. A target of 600 patients should be achieved by the autumn of 2011; many European sites are currently involved.

Another trial of minimal intervention surgery (MISTIE) is evaluating the role of intracavity tissue plasminogen activator with catheter drainage also for supratentorial spontaneous haematomas. A third ongoing prospective randomised controlled trial (CLEAR III) is randomising patients with ventricular haemorrhage to intraventricular recombinant tissue plasminogen activator administration compared to placebo and catheter drainage. Efficacy of this approach has been shown so far only in small prospective trials [90, 91].

Clinical trials with clearly defined selection criteria on surgical management of cerebellar ICH and hydrocephalus are needed. Also, the question when to place, change or replace an external ventricular drain in patients with ICH-related hydrocephalus needs to be answered in controlled clinical trials.

Conclusion and Perspectives

Spontaneous ICH does affect a significant proportion of the European and worldwide population. The mortality is significantly higher than in ischaemic stroke, and the prognosis is still poor, creating a large socio-economic burden. However, very few management strategies are supported by good evidence, and specific research priorities for ICH have been lacking so far in Europe [92]. On the other hand, promising results from studies on pathophysiological mechanisms and from clinical trials, as well as combined efforts from different research focuses in the area, provide optimism for the future.

As response to a lacking European research agenda for ICH, a dedicated academic initiative has now been established to constitute a multicentre European Network for ICH research (called EURONICH, see the appendix). The network focuses on setting research priorities, planning and executing high-impact large clinical studies, including controlled clinical trials, the collection of blood samples for DNA and biomarker studies, a brain imaging archive, and a brain tissue bank for deciphering molecular and cellular mechanisms of ICH and its underlying disease entities. Multidisciplinary diagnostic and therapeutic strategies should be optimised sharing the expertise of vascular neurology, diagnostic and interventional neuroradiology, neurosurgery, anaesthesiology, neuropsychol-

ogy and rehabilitation, to name but a few. The ultimate aim is to improve patient care across all member states of the European Union, and beyond. Interested colleagues and neurovascular teams in Europe are welcome to join the effort (<http://www.euronich.de>).

Appendix

EURONICH is an initiative of researchers and their coworkers in the field of ICH from 14 European countries (<http://www.euronich.de>). It is an open network that welcomes other clinical and basic science researchers to participate in this multidisciplinary collaboration. Finances used to make the EURONICH initiative come to life come from money that is supplied by institutional research support, as well as from research grants and ongoing clinical studies in the area of ICH.

Members of EURONICH have performed several planning meetings on research projects and scientific sessions during the European Stroke Conferences in 2009 (Stockholm, Sweden), 2010 (Barcelona, Spain) and 2011 (Hamburg, Germany).

Currently funded ICH-related studies within the EURONICH network include: (1) ARUBA – A randomised trial of unruptured

brain arteriovenous malformations; sponsor: NIH/NINDS (USA); (2) INCH – international normalised ratio normalisation in patients with coumadin-related ICH; sponsor: Heidelberg University Hospital (Germany); (3) INTERACT2 – Second Intensive Blood Pressure Reduction in Acute Cerebral Haemorrhage Trial; sponsor: National Health and Medical Research Council (Australia).

Disclosure Statement

Hanne Christensen has received research funds from the Capital Region of Denmark and Medtronic Inc., and speaker and advisory honoraria from Boehringer-Ingelheim Danmark A/S, Medtronic Inc. and Allergan A/S.

Christian Stapf has received research funds through grants from the NIH/NINDS (USA), the Australian National Health and Medical Research Council and the French Ministry of Health.

Erich Schmutzhard has received research funds from Actelion and Bayer Austria, and speaker honoraria from Actelion, Novo Nordisk and Baxter.

Thorsten Steiner has received research funds from Octapharma, and speaker honoraria from Novo Nordisk and Octapharma.

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